

## Engaging Religious Institutions to Address Racial Disparities in HIV/AIDS: A Case of Academic-Community Partnership

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African Americans face the most severe burden of HIV among all racial and ethnic groups. Direct involvement of faith leaders and faith communities is increasingly suggested as a primary strategy to reduce HIV-related disparities, and Black churches are uniquely positioned to address HIV stigma, prevention, and care in African American communities. The authors describe an academic-community partnership to engage Black churches to address HIV in a predominantly African American, urban, southern Midwest location. The opportunities, process, and challenges in forming this academic-community partnership with Black churches can be used to guide future efforts toward engaging faith institutions, academia, and other community partners in the fight against HIV.

**Keywords:** *community-engaged research; HIV/AIDS; Black churches*

Though HIV is a preventable disease, each year approximately 50,000 Americans become infected (Centers for Disease Control and Prevention [CDC], 2012). African Americans face the most severe burden of HIV among all racial and ethnic groups (CDC, 2014), a phenomenon previously labeled as “*AIDS in Blackface*” (Black AIDS Institute, 2006). African Americans carry almost half of all new infections and account for a higher portion of HIV infections at all stages of disease (from new infections to deaths) (CDC, 2014). Reducing HIV-related disparities has become a national goal (White House Office & Crowley, 2010).

Behavioral interventions have not been successful in halting the HIV epidemic among African Americans, and sociocultural approaches are now strongly recommended (Szaflarski, 2013; Szaflarski et al., 2013; Williams, Wyatt, & Wingood, 2010). As one strategy, multi-sectorial collaborations between academic researchers, public health programs, and non-profit community organizations have begun to emerge across the nation. In particular, faith leaders and faith communities are increasingly sought as

partners in the efforts to address HIV among African Americans (e.g., Lightfoot et al., 2012; Nunn et al., 2012; Sutton & Parks, 2013). Black churches have historically been the pillar of African American communities and played a crucial role in social justice issues; however, they have also been identified as perpetuating HIV stigma and discrimination, thus halting efforts to curb HIV rates among African Americans. The National Association for the Advancement of Colored People (NAACP) has issued a call to action, establishing guidelines for Black churches to become involved in the fight against HIV (NAACP, 2014).

There is a surging literature describing faith-based HIV efforts in high HIV-prevalence areas—that is, the East and West Coasts and the Southeast (e.g., Coleman, Lindley, Annang, Saunders, & Gaddist, 2012; Cunningham, Kerrigan, McNeely, & Ellen, 2011; Derose et al., 2010; Derose et al., 2011; Nunn et al., 2012)—but little attention has been given to low-to-moderate prevalence areas. There is a growing concern about a potential future HIV epidemic in those areas because of spiking rates of sexually transmitted infections (STIs), conservative culture, and limited resources for HIV prevention and care (Hamilton County Health Department, 2014a, 2014b, 2014c). This paper describes an academic-community partnership to engage Black churches to address HIV in a predominantly African American, urban, southern Midwest location. Our main research questions were: (1) Are academic-community partnerships involving Black churches a feasible strategy for tackling HIV in low-to-moderate prevalence areas?, and (2) What are the facilitators of and barriers to successful collaboration among academic and community partners who are developing faith-based HIV interventions? Lessons learned from our project are discussed in light of existing theory and literature, and these lessons can be used to guide future efforts toward engaging faith institutions, academia, and other community partners in the fight against HIV.

## **Background**

### **Religious Organizations and HIV**

Religious organizations have long been a part of the HIV epidemic (Beckley & Koch, 2002; Keough & Marshall, 2007). Religion, a key element of culture, is important to the issue of HIV because it shapes ideas about sexual behaviors and lifestyles associated with HIV risk, and it influences perceptions of and care for people living with HIV. In addition, religious congregations can offer HIV-related programs and services as part of their longstanding commitment to social service and community work, especially in urban and disadvantaged areas (Beckley & Koch, 2002; Cnaan, 2006; Wuthnow, 2004). However, religious organizations' responses to HIV have been mixed. On the one hand, religious organizations have cared for people dying of AIDS, mostly early in the epidemic (Beckley & Koch, 2002); on the other, religious organizations have often reflected the social norms—characterized by stigma and denial—that have both contributed to the spread of and hindered efforts to prevent HIV (Keough & Marshall, 2007).

The growing literature addresses the role of U.S. Black churches in the HIV epidemic (e.g., Agate et al., 2005; Aholou, Gale, & Slater, 2009; Foster, Cooper, Parton, & Meeks, 2011; Griffith, Pichon, Campbell, & Allen, 2010; Harris, 2010). Black churches are considered a conservative institution. Many Black religious leaders perceive HIV as a moral problem and often deny its existence or are silent about the epidemic, even though they may be personally involved in HIV prevention efforts (Eke, Wilkes, & Gaiter, 2010). Some urban faith communities have begun community mobilization against HIV—for example, The Balm in Gilead, Inc. in New York and The Ark of Refuge in San Francisco (Eke et al., 2010; Gilbert, 2003; Harris, 2010). These programs have offered HIV educational programs, testing, compassionate support (to people living with HIV), and related services (e.g., substance abuse programs). More work is needed to understand how these community programs can be formed and sustained, especially in areas of low-HIV priority.

## HIV-Related Stigma and Discrimination

Stigma is a major barrier to effective HIV prevention and care (Institute of Medicine [IOM], 2011; Mahajan et al., 2008). Goffman (1963) defined stigma as “an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one” (p. 11). Stigma has recently been re-conceptualized as a sociocultural phenomenon (versus individual-level experience) and argued to be a fundamental cause of health disparities (Hatzenbuehler, Phelan, & Link, 2013). In the HIV field, stigma is often defined as “‘a process of devaluation’ of people either living or associated with HIV and AIDS” (Joint United National Programme on HIV/AIDS [UNAIDS], 2003). Action resulting from HIV-related stigma consists of HIV-related discrimination, or the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Fear of discrimination may prevent people from testing or seeking treatment for, or disclosing their HIV status (IOM, 2011; Mahajan et al., 2008). Community-level HIV stigma reduction interventions have been shown effective (Tedrow et al., 2012; USAID/AIDSSTAR-ONE, 2011). The key elements of success are the community ownership of the stigma reduction process and tailoring the program to the unique social setting.

Black churches have been contributing to the continuing stigma and discrimination against people living with HIV, especially men who have sex with men (MSM) (Eke et al., 2010; Griffin, 2006). Black MSM members of congregations are often expected to keep silent about their sexual orientation. This “don’t tell” attitude extends to HIV status, if the members have HIV. A study of HIV-infected patients showed that people living with HIV who seek religious affiliation often engage in “church-hopping” because they do not always feel welcome due to their HIV status and gay lifestyle (Szaflarski et al., 2009). Thus, religion may reinforce stigma conditions that predispose individuals to HIV infection and limit their ability to access HIV testing and treatment.

## Shift to Community-Engaged and Community-Partnered HIV Interventions

It has been argued that “to best combat the HIV/AIDS epidemic within the African American communities, researchers, clinicians, and community partners must collaborate to develop culturally congruent HIV interventions that go beyond traditional categories” (Williams, Wyatt, & Wingood, 2010, p. 193). The specific recommendations are as follows: Apply theories and conceptual frameworks that are pertinent to African Americans and their sociocultural context (e.g., traditional norms imposed by churches and faith agencies); draw on strengths of African American communities; stress HIV risk reduction and prevention messages; establish multidisciplinary collaborations; be sensitive to multiple minority statuses (“overlapping risks”); and train all partners in cultural competency. Faith communities are well positioned to take part in this work, but further mobilization and empowerment of Black faith communities are needed and can happen through broader community partnerships. In our research, we investigated whether academic-community partnerships involving Black churches are a feasible strategy to tackle HIV in low-to-moderate prevalence areas. Furthermore, we examined the facilitators of and barriers to successful collaboration among academic and community partners who are developing faith-based HIV interventions.

## Community-Engaged Research Frameworks

Our work was grounded in the established principles of community engagement and community-engaged scholarship, which are becoming integral parts of public health interventions and have great potential to help reduce and eliminate health disparities (Clinical and Translational Science Awards Consortium [CTSA], 2011). *Community engagement* has been defined as “the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to health issues affecting their well-being” (CDC, 1997, p. 9). Community engagement varies in form and can occur on a continuum of community involvement in several stages: from *outreach* (some

involvement, one-way communication) to *consultation* (more involvement, two-way communication, connections), to *involvement* (participatory communication, partnership), to collaboration (community involvement, partnership/trust building), and, finally, to *shared leadership* (strong bi-directional relationship, joint decision-making, trust) (CTSA, 2011). Several positive outcomes of community engagement have been identified (Staley, 2009), including (1) the opportunity for community organizations to gain enhanced knowledge, a higher profile, more linkages, and new organizational capacity, which can create goodwill and help lay the groundwork for subsequent collaborations, and (2) a more favorable reception and adoption of research evidence by lay community members for their own benefit (CTSA, 2011).

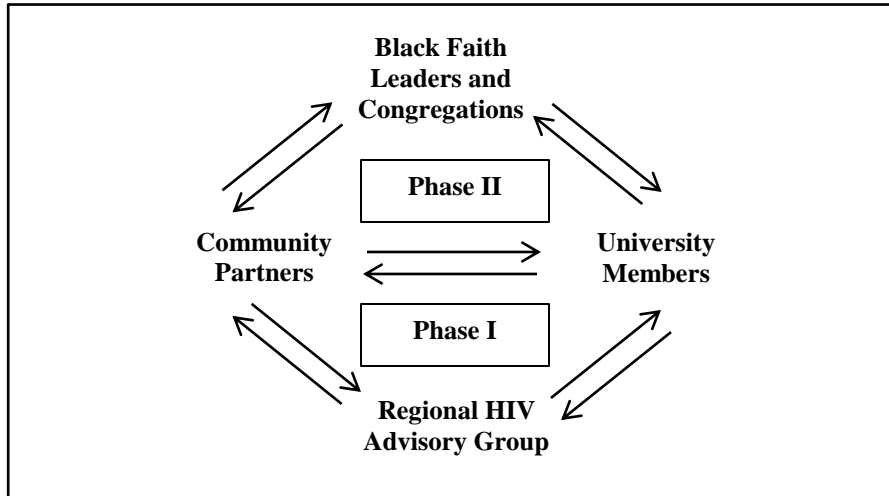
Thompson and colleagues (Thompson, Head, Rikard, McNeil, & White, 2012) have proposed a conceptual framework specifically for engaged scholarship on HIV interventions in the African American community. The framework focuses on bridging cultural divides through cooperative learning and empowerment of community members. One key assumption of this framework is that community members are often passive in their learning of HIV-related information. A transformation is needed to turn community members into change agents versus passive recipients of information. Within this framework, community members are engaged in problem-posing through asking and reflecting on questions, such as “Why do you think the rates of HIV are so high among African Americans?” (Wallerstein & Bernstein, 1988). This process then leads to sharing common experiences and knowledge related to HIV and, ultimately, to forming action plans. Thompson et al. (2012) identified five specific strategies for bridging cultural divides and bringing academic and community partners together to address HIV: (1) connecting with cultural insiders (discovering and learning the cultural context); (2) building collegiality (developing and strengthening personal relationships and building trust between academic and community partners, then reinforcing acceptance and respect); (3) developing shared goals and aims (accountability and attending to each other’s interests); (4) identifying complementary and diverse skills (recognizing and sharing each other’s expertise); and (5) sustaining the collaboration.

We followed Thompson et al.’s (2012) framework in describing and discussing our academic-community collaboration and project. Specifically, our work occurred in two phases and involved several groups of stakeholders (Figure 1). In Phase 1, university and community partners (including members of an HIV regional advisory group) came together to discuss the local religion-HIV context; it was the first opportunity for researchers to *connect with cultural insiders*. During this phase, a core group of stakeholders worked to *build collegiality and trust; develop shared goals and aims; identify and share complementary expertise; and seek funding* for community-based work.

Phase 2 occurred during a funded project that involved a group of local churches and additional community partners. All activities of Phase 1 and Phase 2 were designed to provide ample opportunities for cooperative learning and two-way communication among all partners (dual arrows in Figure 1). Cooperative learning in Phase 1 occurred between the academic and community partners, while Phase 2 stressed cooperative learning, empowerment, and mobilization aimed at the participating church leaders and representatives.

## **Community-Engaged Project**

Our community-partnered project focused on addressing HIV stigma and HIV prevention and care with a group of Black churches serving predominantly African American, high-HIV risk urban neighborhoods. The project was initiated by a group of academic and community partners and aimed to educate and empower faith leaders and congregations to address HIV stigma and HIV prevention and care in their communities. The project was approved by the University of Cincinnati Institutional Review Board.



**Figure 1.** Framework for community-engaged research addressing HIV in African American faith communities.

## Geographic Context

We conducted our work in Cincinnati, Ohio. Prior research in Greater Cincinnati has examined factors shaping faith-based HIV prevention and counseling programs (Szaflarski et al., 2013) and community perceptions of barriers and opportunities for faith-based HIV prevention (Szaflarski, Vaughn, McLinden, Wess, & Ruffner, 2014, 2015). However, the process and outcomes of academic-community efforts addressing HIV through faith-based efforts in this geographic area have not been documented. Cincinnati is Ohio's largest metropolitan area, with 40% of its population residing in Hamilton County. There are an estimated 287 per 100,000 people in Hamilton County living with a diagnosis of HIV infection (Ohio Department of Health, 2013). Cincinnati is considered a low-to-moderate HIV prevalence area and has been funded repeatedly under the expanded testing initiatives (CDC, 2011a) to increase identification rates of undiagnosed HIV infection in neighborhoods disproportionately affected by HIV, particularly predominantly Black neighborhoods. HIV prevention in low-to-moderate prevalence areas, such as Cincinnati, is likely to differ from prevention in high-prevalence areas, and results from programs conducted in high-prevalence areas (e.g., the 12-Cities Project [CDC, 2011b]) might not be readily transferable to lower-prevalence areas. In lower-prevalence areas, the epidemics are more likely to involve stigma and more likely to involve subgroups (rather than be generalized), so the harmful or beneficial effects of institutions (such as churches) might be uniquely profound.

## Institutional Context

The academic partner in this project was the University of Cincinnati (UC), a research-extensive, public university which houses a federally funded Center for Clinical and Translation Science and Training (CCTST; <http://cctst.uc.edu>). A large part of the CCTST program and resources are devoted to the *Community Engagement and Research Core*, which aims to broaden and strengthen collaborations between the UC Academic Health Center and the community. Resources include the Community Partner Council, comprising over 30 community members, neighborhood activists, and academic members who facilitate connections through advice, education, and action; the Community Leaders Institute (CLI), a six-week leadership development training program designed to enhance community research and capacity building competencies in community leaders; the Community Engagement Speaker Series; and the Community Health Grant program. These resources were critical to our project. In 2012, we were

awarded a one-year CCTST Community Health Grant to work with a group of local Black churches to educate, reduce HIV stigma, and mobilize the faith community against HIV. Within the scope of this project, our community partners attended the CLI and other community engagement programs offered by the CCTST.

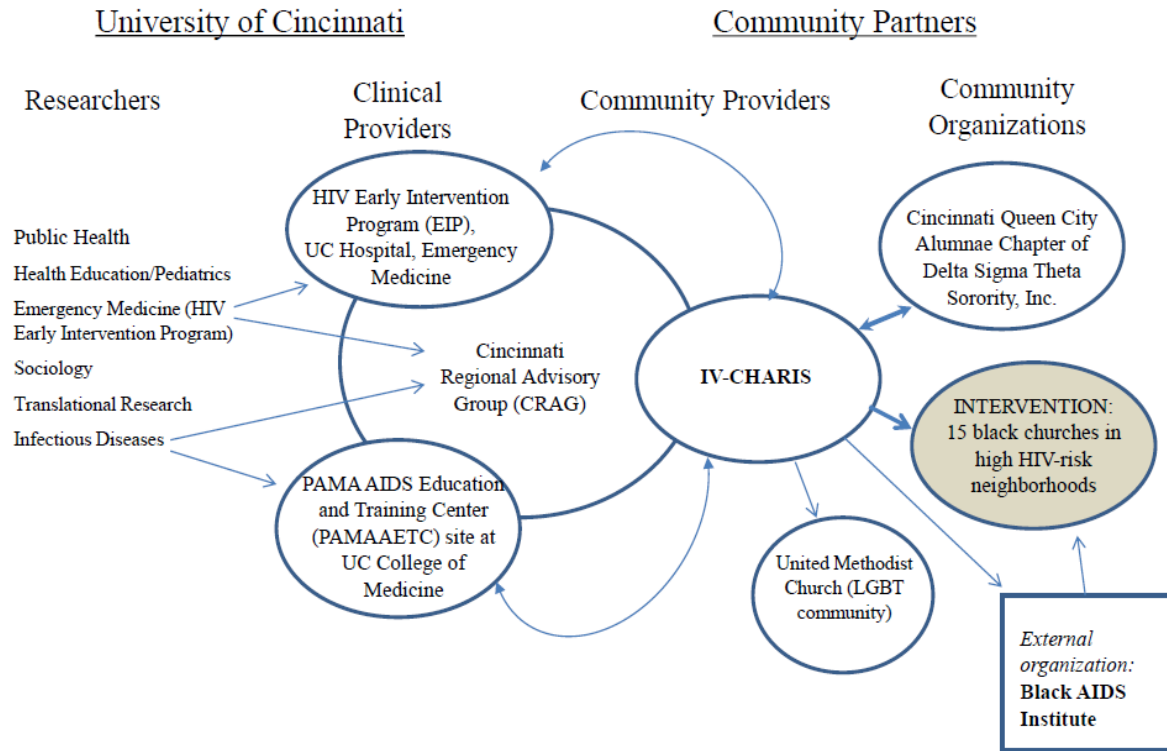
## **Phase 1: Academic-Community Partnership – How We Came Together**

The academic partners on this project included medical and public health researchers and clinical partners and leaders of the Local Performance Site of the Pennsylvania Mid-Atlantic AIDS Education and Training Center (PAMAAETC) and the Early Intervention Program (EIP). The community partners included: IV-CHARIS, a community-based HIV/STD service and advocacy organization; the Cincinnati Queen City Alumnae (CQCA) Chapter of Delta Sigma Theta Sorority, Inc.; and a network of Black churches (see Tables A1 and A2 in Appendix A) for fuller descriptions of the clinical and community partners). The map of the academic-community partnership is shown in Figure 2.

Members of our team are part of the Cincinnati Regional Advisory Group (CRAG), the community planning group responsible for local HIV programs. In September of 2011, CRAG sponsored the Cincinnati Black MSM AIDS Conference and Community Forum, along with the Local Performance Site of the PAMAAETC. As part of a continuing education program for counselors, social workers, and nurses, the conference featured a session on religion and HIV. The conference was followed by a guided discussion with the general community about ways to improve local HIV prevention. The forum discussion groups provided insights on community perceptions of HIV risk among Black MSM; the relationships between homophobia, stigma, and HIV; and best practices in engaging Black MSM in prevention and treatment.

The final portion of the discussion session was to identify helpful actions that different types of *social institutions* could take to improve prevention efforts. The top three actions identified for *faith-based organizations* were to (1) educate church leadership about HIV transmission trends; (2) explore other churches' successful education and outreach best practices; and (3) encourage church leaders to get tested, thereby serving as role models for their congregations.

The synergies among the partners became clear during preparation of the conference and community forum. In a series of meetings afterwards, the partners developed a common vision for a project targeting Black faith leaders and congregations to reduce HIV stigma and enhance HIV prevention and care in local communities. Between October 2011 and January 2012, the community and academic partners held several face-to-face meetings and continued to work via email and phone between the meetings to develop a program that would focus on educating faith leaders on HIV/AIDS and discuss how faith leaders can be a resource for the community for those living with HIV (e.g., how to prevent stigma, programs the church can offer, etc.). In October 2011, IV-CHARIS began meeting with local faith leaders (e.g., representatives of the Christian Community Council) to assess the faith community's readiness to engage on the issue of HIV. IV-CHARIS successfully networked with female pastors and secured a Black female bishop's commitment to the program. The leaders of IV-CHARIS also met with other bishops in an effort to extend their contacts beyond their usual pastors and churches. The outcome was a list of 50 potential pastors to network with once the program was finalized. In early November 2011, IV-CHARIS and CQCA met with the academic partners regarding potential funding opportunities. In January 2012, the academic-community partners submitted two grant applications, a CCTST Community Health Grant and a R01 project application to the National Institutes of Health.



**Figure 2.** Map of the academic-community partnership addressing HIV in Cincinnati's African American faith communities. Academic disciplines/affiliations represented by the research and clinical partners are noted on the left.

## Phase 2: CCTST Community Health Grant

The CCTST project was funded in March 2012. The project was premised on our belief that if we could change Black faith leaders' attitudes about HIV so they would recognize the burden and threat of HIV and encourage education/prevention efforts in their communities, then we would be able to reduce stigma in the broader community—leading to higher rates of testing, fewer infections, and better treatment of people living with HIV (key goals of the National HIV/AIDS Strategy; White House Office & Crowley, 2010). The first aim of our community project (March 2012 - February 2013) was to conduct a series of educational programs and community discussions with Black faith leaders and churches in the two highest HIV-risk neighborhoods (Avondale, Price Hill). This program included leading structured workshops and events (Appendix B) and continuing networking and individual consultations with churches.

The additional aims of our project were to strengthen our academic-community partnership and empower our community partners as community health leaders. Notably, early in the project, all partners attended a facilitated partnership-building workshop which resulted in a common set of written goals and strategies to address HIV in the Black faith community (see Table 1). In addition, the community partners became engaged in various types of academic- and research-related activities. For example, they attended the CCTST-based Community Leadership Institute and Community Engagement Speaker series. They also participated and co-presented our project at the CCTST annual outreach events for grant awardees. In addition, with guidance from the research partners, the community partners completed research ethics certifications required for community-engaged and community-partnered research

activities. Furthermore, the community partners collaborated with the research and clinical partners on two research conference submissions and presentations and two scholarly manuscript submissions.

Phases 1 and 2 of our project demonstrated that establishing an academic-community partnership to address HIV through faith-based efforts was feasible in our area, and the outcomes signaled a great potential for such collaboration. Thus, the information from this project supported our first research question.

**Table 3.** Goals and Strategies Identified in Academic-Community Partnership-Building Session

<b>Goals</b>
1. Address stigma and increase understanding
2. Engage and mobilize the community for change
3. Address funding challenges
4. Spread the word through media
<b>Strategies</b>
1. Partnership – Listening and communicating; utilizing collective strengths
2. Education – In the community and each other (needs, goals)
3. Attention to mission – funding to achieve common goals
4. Sustainability (partnership, efforts, services)
5. Remove barriers to working together (within, others – communication)
6. Need more face time – partnership
7. HIV/AIDS – address stigma and increase understanding (community and churches)
8. Engaging and mobilizing the community for change (education, relevance, HIV, champions, achievements/efforts)
9. Address funding challenges – HIV/AIDS (county) – also partnerships as a whole
10. Spreading the word/media – HIV/AIDS (churches' role)

## **Perspectives and Lessons Learned about Academic-Community Partnerships and Engagement**

To evaluate the partnership and project process, two representatives from each stakeholder group—community, clinical, and research—answered 20 questions about the partnered experience (see Appendix C for process evaluation questions). Responses to these questions were categorized according to Thompson et al.'s (2012) five strategies for academic-community partnerships to address HIV (see earlier description and bolded text below). The evaluation stage of the project aimed to shed light on our second research question about factors that facilitate and hinder academic-community collaborations involving Black churches in HIV prevention and care.

### **Partnership is Critical**

Community, clinical, and research partners all voiced the mutual benefit and necessity of partnering to address HIV/AIDS in the Black faith community. The community partners felt that the clinicians and researchers legitimized the work they had been doing in the community for years and provided assistance with funding and documentation of process and outcomes. Clinical and research partners described the importance of collaborating with the community partners in order to engage with members of the Black



faith community (**connecting with cultural insiders**). Clinical and research partners recognized the essential role of the community partners to provide a bridge into a community of people who would have otherwise likely been distrustful, especially of the academic researchers. All partners indicated that the work would not have been possible without the inclusion of the other partners and that for real change to occur the community must be directly involved in defining the problem and helping to find solutions. Each team member described the unique contribution of the other partners, suggesting that without each person's role the project would not have been as successful. Likewise, all team partners mentioned that the individual skills, expertise, and background that they each brought to the table were not sufficient to address the complex problem of HIV in the Black faith community (**identifying complementary and diverse skills**). For instance, one research member indicated that she could not do the work on the ground within the (Black faith) community because she lacked connections, whereas the HIV prevention community partners were also part of the Black faith community through their ministry and had existing relationships with many of the churches that became involved in the project.

## Engagement of Black Churches

According to all partners, the most important part of the partnership and project was working together as a team to engage Black churches (**developing shared goals and aims**). The community partners specifically mentioned the success of the community forum where varied stakeholders were represented (e.g., clinical professionals, church members, pastors, HIV agency members, family members, members of the gay and lesbian community, etc.) and the stigma training for the participating churches. Most of the partners described the interactions with the Black churches as a challenging part of the shared goals. The community partners described the churches and some of the pastors as being difficult to engage because of their varying degrees of comfort with the topic of HIV. The clinical and research partners again affirmed that engagement with the churches and pastors would not have been possible had it not been for the long established relationship of the community partner teams and their respected agency in the Black faith community (**connecting with cultural insiders**). Community partners continually emphasized the importance of meeting the pastors and churches "where they are" rather than imposing a program or our set of values. Community partners often reminded the other partners about not pushing too hard and allowing each pastor and church to engage based on their own level of comfort.

## Effective Partnerships

The partners noted the challenge of building the partnership and how the process depended on mutual understanding and respect, transparent and straightforward communication, and learning to solve problems together (**building collegiality**). One research partner expressed that "there was a lot of good will, mutual respect, and attempts to understand each other." Identifying and understanding the specific roles and diverse skills of the various partners required time and commitment. For instance, the community partners initially did not understand the research process and were distrustful of the possible agenda of the researchers and clinicians based on previous interactions with the university and medical center which they described as being hierarchical and "one-way." One partner said:

There has to be a lot of two-way communication, frequent meetings, to get on "one page" with people. It is important to be open-minded, respectful of all opinions, try to put yourself in the other party's shoes, be attuned to any emerging misunderstandings or disagreements, and address them as soon as possible and openly.

Researchers and clinical partners initially expressed some worry that the values and attitudes of the community partners were too different (e.g., stance on condom use and abstinence) and could interfere with the success of the partnership (**developing shared goals and aims**). However, in response to the

process evaluation questions, all partners reported no surprises regarding the process of coming together as a unified group; partners said that some degree of conflict and “storming” is expected when forming a group and that false expectations and assumptions just take time to work through. A community partner described the importance of clarifying roles, time commitments, and funding in the planning phases. She said that each partner has to “be willing to learn to do things in different ways and to be willing to commit over a long time period.” All partners said that over time everyone meshed well, and at the end of the grant period all expressed interest in continuing to work together (**sustaining the collaboration**).

## Community-Engaged Approach

All partners identified the community-engaged approach as the best and worst part of the partnership—best because it required everyone to work as a unified group, appreciating and respecting one another’s strengths (**building collegiality**), and worst because the work required tremendous time and energy which were hard to sustain. A research partner cautioned about the necessity to devote a lot of time to the partnership which ideally would not occur when working on academic promotion and tenure. One of the evaluation questions asked about the level of community engagement reached within our partnership. All partners indicated that we definitely progressed through the stages of community engagement. Most partners felt that by the end of Phase 2, our group had reached shared leadership among academic, clinical, and community partners. One clinical partner said that a community-engaged approach is the only way to do this type of work:

[W]ithout a committed partnership team with different expertise and different connections, working for social change becomes virtually impossible. It is hard to see how to do the work in any other meaningful way. It becomes so much more than just research or just advocacy or just education or just outreach—it’s the combination within a partnership framework that is really powerful.

Consistent among all partners was the necessity for passion and commitment for community work regardless of position within the actual community. All partners described the importance of having the “right” type of people to do community-engaged work and to be part of an academic-community partnership; that is, “not everyone could do this type of work.” Partners described the essential role of gatekeepers, liaisons, and/or bridges within each of the constituent groups. For example, the community partners were gatekeepers for the Black faith pastors and community members (**connecting with cultural insiders**). The community partners mentioned that part of the reason they were open to building a partnership with academic researchers and clinicians was because of a previous relationship with a physician who sought out their agency’s opinions and really listened to their perspective about HIV/AIDS in the Black faith community. One of the clinical partners was a liaison and bridge between the community partners and the research partners. Another clinical partner served as a gatekeeper to a particular population within the Black faith community. One of the research partners provided a bridge between the university and other researchers with the clinical and the community partners. One partner mentioned that once you have the right type of people, you have to make sure to spend quality time together, including food and fellowship time and celebrating successes.

## Impact on Black Faith Community

Community, clinical, and research partners all agreed that the partnership and work together did make an impact in the Black faith community; five of the seven churches involved in the partnership have continued to do work related to HIV awareness. One clinical partner lamented that other commitments got in the way of sustained engagement with the partnership (**sustaining the collaboration**). One research partner relocated to another state and position. One clinical partner who is an active member of

a local Black church said that she heard from the churches that they were proud of the work they had done and were energized by the opportunity and planned to continue the work. She said the Black churches also voiced pleasure in the fact that the academic partners cared about them and invested time and effort in them.

## Overall Lessons Learned

All partners in our project agreed that the partnership and our work together would have been improved by more up-front time for planning, including a specific structure and guidelines for sustainability after the project work was completed and more time to build the relationship. Otherwise, lessons learned varied for each of the partners. The community partners said their biggest learning was related to the readiness of the community itself to join the work. Specifically, the community partners described not wasting too much time on people in the community who were reluctant to join the work and take ownership of the procedural process for the church. A clinical partner indicated her overall satisfaction of working in the community within an academic-community partnership framework, noting “an affirmed belief in the community and its need to be involved in the creation of solutions for its problems.” Another clinical partner expressed struggles with the seemingly “distinct realms of university and community” and the desire for increased opportunities for two-way dialogue between academics and communities. The research partners described their privilege and satisfaction of being able to engage with community members unlike themselves in terms of different racial, ethnic, and cultural backgrounds, and the opportunities this provided in terms of professional and personal growth. A research partner described this partnership as a critical “career experience” with exposure to new ideas, perspectives, and attitudes, all of which contributed to an enhanced understanding of community-engaged research and academic-community partnerships.

## Discussion

This paper describes the opportunities, process, and challenges in forming academic-community partnerships to address HIV among African Americans through engaging Black churches. Our study showed that such partnerships are feasible in our community, and it highlighted factors that facilitate such collaborations. Two key opportunities illustrated in our work include the availability of institutional resources for community-engaged research and the presence of community champions connected to both the academic and faith communities. These specific assets formed a foundation for synergies which, in turn, moved the academic-community partnership from the stage of outreach and consultation to the subsequent stages of mutual involvement, collaboration, and shared leadership. Several themes and lessons emerged from the various partners’ perspectives on this partnership’s processes and outcomes, such as the importance of academic-community alliances in engaging the faith community and the challenges and rewards of working together. Specific strategies for building effective partnerships and faith-community-engaged and -partnered HIV interventions, such as building collegiality and trust, and connecting with cultural insiders, were similar to those identified in other community-partnered HIV programs (Thompson et al., 2012).

The results reported here have several limitations. For instance, our work was context-specific and qualitative; thus, it is not necessarily generalizable to other community settings. However, the themes and lessons that emerged from our academic-community partnership and project are similar to those reported in other faith-community-engaged HIV programs across the country (Derose et al., 2010, 2011; Foster et al., 2011; Lightfoot et al., 2012; Nunn et al., 2012). Also, our program was a frontier effort in our community, aiming, in part, to test the feasibility of a larger future HIV intervention through Black churches. As such, the program had a limited scope and involved a small group of partners and churches. Challenges encountered along the way (e.g., the transition of key partners and support staff) made

sustaining a robust data collection and process evaluation difficult. These shortcomings are reflected in the process evaluation.

Despite these limitations, lessons from this project inform our understanding of local opportunities and challenges to build academic-community collaborations with the faith community to address HIV among African Americans. The churches participating in our program were open to learning about HIV and welcomed a discussion of issues ranging from HIV epidemiology and prevention to stigma. However, they proceeded with caution in developing their own HIV-targeting action plans. Specifically, all of the participating churches committed to establishing themselves as educational and resource centers for HIV prevention and care, but none was yet ready to play a more active role—for example, by opening doors for on-site HIV testing. There was also a group of churches that did not join the network, despite our repeated attempts at recruitment. This mixed pattern of responses is consistent with findings reported for similar programs (Nunn et al., 2012; Williams et al., 2011). Congregational responses to HIV have been reported to vary from low-level (e.g., educational programs) to higher-level involvement (e.g., advocacy, partnering with public health prevention and testing programs) (Derose et al., 2010, 2011). On the other hand, Black churches that offer HIV programming typically provide a range of programs that includes education, counseling, and testing (Szaflarski et al., 2013). Our project may have involved a group of churches that were at a lower level of HIV readiness and/or were taking a more conservative approach to HIV. This actually is a positive outcome of our program, as our goal was to empower the less engaged congregations, so that they can start making a difference in areas of high HIV need.

One important lesson gained from the community partners in this project is that churches must be allowed to work out the HIV issue within the framework of their own doctrine. Research shows that even conservative churches can be engaged in HIV prevention and care efforts without compromising their theological positions and values (Derose et al., 2010, 2011). Also, the most subtle efforts and involvement with other partners (i.e., researchers and providers) have a great potential to mobilize churches over time. Accordingly, our approach was to educate and counsel churches but not impose a “one size fits all” strategy. Therefore, in addition to structured programs, we assisted churches individually to move forward with their HIV-related goals, which matched their unique cultural and structural situations (i.e., doctrine and resources). Based on the feedback from the community, we believe that this approach was successful within the limited scope of our project and advocate for its broader application.

## **Conclusion**

Black churches are uniquely positioned to address HIV stigma, prevention, and care in African American communities. The low levels of readiness to act in some faith communities may be related to a low perceived risk of HIV, denial, or poor knowledge of the scope of the local HIV epidemic. Educating and empowering churches is critical and can be done with multi-sectorial support including academic institutions and clinical providers. Lessons learned from small-scale projects like this one can be used to build larger programs in specific settings, but there are also general strategies and principles for effective partnership-building and community engagement that apply across various settings. Future multi-site projects which consider several different community contexts, networks, and collaborations, may provide additional information about the more universal and context-specific aspects of faith communities’ involvement in HIV prevention and care.

## Appendix A

**Table A1.** Descriptions of Clinical Partner Programs

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### **AIDS Education and Training Center**

The Local Performance Site of the Pennsylvania Mid-Atlantic AETC (PAMAAETC). UC LPS IDC is the only HIV/AIDS specialty center within a 100-mile radius of Cincinnati. There are approximately 200 patient care visits per week, and 8-14 new patients are evaluated monthly, the majority of whom are antiretroviral-naïve. Since its inception, the IDC has cared for over 3,600 individuals with HIV/AIDS. The AETC provides HIV/AIDS-related training and technical assistance. The AETCs are a network of 11 regional centers funded by the Ryan White Care Act through the HRSA Bureau of HIV/AIDS and includes more than 100 local sites representing all 50 states and US territories. The centers are working in a number of ways to support the goals set out in the National HIV/AIDS Strategy. In aiming to reduce new HIV infections, the AETCs provide cutting-edge training programs regarding HIV transmission, prevalence, and prevention with a focus on risk-reduction processes and motivational interviewing skills. Between July 2008 and June 2009, the AETC network conducted 642 trainings for 22,669 health care providers focused on implementation of the CDC HIV testing recommendations. The AETCs are also engaged in activities specifically in support of reducing HIV-related health disparities and inequities. Through funding by the Minority AIDS Initiative (MAI), the AETC network has put special emphasis on recruiting minority health care personnel for training regarding HIV. In fiscal year 2008-2009, 44% of all AETC trainees were racial or ethnic minorities themselves, and the vast majority of trainees serve a largely minority population. Health care providers serving communities of color, women, LGBTs, prisoners, the homeless, the uninsured, and drug users also are targeted for training. Training is also given to primary care personnel and other health care providers to promote early diagnosis and decrease stigma associated with HIV, leading to better outcomes. The UC LPS of the PAMAAETC has been providing technical assistance to community partners and assisting in education, linkage, and outreach efforts aimed at religious organizations and faith communities.

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### **HIV Early Intervention Program (EIP)**

EIP provides HIV counseling, testing, and referral services in the Emergency Department (ED) of University Hospital, the primary health resource for the uninsured in Cincinnati and Hamilton County. The Ohio Department of Health (through the Cincinnati Health Department) and Cincinnati Health Network (through Ryan White funds) have funded the program continuously since 1998. The University Hospital ED is an ideal location to reach populations at high risk for HIV, who may not access other community-based organizations or health facilities. Specifically, the EIP has been very effective in reaching patients affected by psychiatric illness, substance abuse, homelessness, and incarceration. For the 2011 program year, prior to this project's start, the EIP provided 2,580 tests. Of the population tested, 68% were African American, 48% were male, 4% were MSMs, 33% were age 24 years or under, 36% were women of color, and 9% were injection drug users. The test positivity rate for confirmed new positives in 2011 is 0.96% (25 positives). Across all complete program years (1998-2010), the average positivity rate was 0.8%. EIP collaborates with various institutional and community partners, including the Central Community Health Board, community health service organizations, and the Cincinnati Health Department, and plays an active role in the Cincinnati Regional Advisory Group for HIV programs and funding.

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**Table A2.** Descriptions of the Community Partner Organizations**IV-CHARIS** (*Compassionate Hearts Assisting, Rebuilding, Instructing and Serving*)

IV-CHARIS is the only faith-based organization in Cincinnati that is state-qualified to conduct HIV/STD testing, counseling, and education. IV-CHARIS is certified by the Ohio Department of Health and highly regarded on a local and state level for its dispensation of quality, state-of-the-art HIV/STD and abstinence services. In response to growing HIV risks in the African American communities, the organization had grown 100% in the two years preceding the inception of this project, and expanded from offering substance abuse preventive services/housing to a myriad of programs in the following five areas: HIV/AIDS testing/screening, risk reduction counseling, referral services, STD education, and He Intends Victory (Support Services). The IV-CHARIS abstinence program provides HIV/AIDS education to court adjudicated youth and those in public and private schools. The mission of IV-CHARIS is to reduce the transmission of HIV/AIDS in underserved communities by creating a non-traditional holistic healing environment that is committed to providing safe and confidential testing, education, prevention, and intervention serviced by caring and well-trained people. Through its special efforts in testing at innovative places, during the first quarter of 2011 IV-CHARIS was 1,500 above the normal testing load. The organization is partnering with local and state health departments, major civil rights organizations, and other community groups to encourage more extensive testing. Additionally, IV-CHARIS has an excellent reputation for collaborating with local organizations such as Correctional Medical Services, Talbert House (addiction recovery program), Greater Cincinnati Coalition for the Homeless, Central Health Board of Hamilton County, City of Cincinnati Board of Health, and the UC IDC to strengthen their cause and bring together a united message in delivering HIV preventative care.

**Cincinnati Queen City Alumnae (CQCA) Chapter of Delta Sigma Theta Sorority, Inc.**

Delta Sigma Theta Sorority, Inc. is an international sisterhood committed to public service. Chartered in 1989, the CQCA has implemented and sustained numerous programs in Greater Cincinnati. These outstanding contributions have resulted in national recognition of chapter programs including awards for promoting awareness of clinical depression and enabling young girls to develop their math, science, and technology skills, and health and wellness initiatives. The CQCA has partnered with individuals, small businesses, and major corporations and as a result have provided more than \$300,000 in scholarships and awards to over 250 young men and women throughout Greater Cincinnati. HIV/AIDS is one of the sorority's national initiatives. The CQCA has partnered with the collegiate Greek organizations and provided HIV/AIDS educational programs on the campuses of local universities. In August 2007, the CQCA along with four local organizations sponsored Sheryl Lee Ralph in her performance of a stirring one-woman play, "*Sometimes I Cry*," a platform for heightening awareness of the impact of HIV/AIDS on the lives of women, especially women of color. Over 700 diverse citizens attended this event. In 2010, the CQCA partnered with IV-CHARIS to carry out *Test 1 Million*, a national campaign to educate, inform, and conduct HIV screenings. The Ohio Celebrity Tour, which began as a pilot project in Cincinnati and then expanded across Ohio, was a collaboration of 27 agencies in the state and the Black AIDS Institute to fight in this effort to end the AIDS epidemic in Black America. Over 400 African Americans were tested during the Ohio Test 1 Million Campaign Tour.

**Cincinnati African American Faith Community**

A network of faith leaders and churches developed by IV-CHARIS. A total of 15 Christian Black churches participated in the project. The churches were located in high-HIV risk neighborhoods (Price Hill, Avondale) and ranged in size from 50 to 4,000 members. The churches were asked to sign a memorandum of understanding (MOU) as a commitment to participate in a one-year project involving structured HIV education and faith community mobilization activities and individual-church consultations. Eight of the churches actually signed the MOU; other churches verbally committed to actively participate in the program.

## Appendix B

### Community Health Grant Project: Timeline of Structured and Other Project Components, Including Educational, Faith-Community Mobilization, and Scientific Activities

#### General Timeline of All Project Activities

- **March 2012:** Networking/recruitment, meetings with key leaders, IRB process, May event planning, evaluation design, kick-off event (prayer service), preliminary data collection from participants, data entry, post-event partner discussion/feedback session.
- **April-May 2012:** Continue networking/recruitment, 1<sup>st</sup> structured event preparation and implementation, event evaluation, data collection, data entry, post-event partner feedback session. Invited presentation at the CCTST Annual Community Breakfast. Participation at the CCTST Annual Community Dinner.
- **June-August 2012:** Follow-up/networking/recruitment, 2<sup>nd</sup> structured event preparation and implementation, event evaluation, data collection, post-event partner feedback session. Submission of an abstract for the 2012 Summit on the Science of Eliminating Health Disparities.
- **September-November 2012:** Follow-up/networking/recruitment, 3<sup>rd</sup> event preparation and implementation, event evaluation, data collection, data entry, post-event partner feedback sessions.
- **December 2012-January 2013:** Follow-up/networking, Closing Ceremony preparation and implementation, data cleaning/analysis, findings compiled and presented to participants at the final event. Presentation at the 2012 Summit on the Science of Eliminating Health Disparities. Submission of an abstract for the UAB Minority Health Disparities Research Symposium.
- **February 2013:** Written final report for CCTST prepared in a form of manuscript suitable for scientific journal submission. Presentation at the UAB Minority Health Disparities Research Symposium.
- **Since February 2013 (“post-CCTST project”):** IRB renewal for follow-up activities. Preparation of two manuscripts for scientific publication; one accepted for publication as of spring 2014). Networking with other organizations (e.g., AIDS Alabama). Media interest.

#### Timeline of Structured Programs/Activities

- **March 2012: Church Service, National Week of Prayer.** An HIV prayer service was held in one of the participating churches during the National Week of Prayer. Representatives of all stakeholder groups were present. The project partners announced the launch of the CCTST-funded community-partnered project to the attending faith community.
- **May 2012: HIV 101 Workshop.** Content was based on the curriculum provided by the Black AIDS Institute and focused on understanding the basic HIV facts, HIV stigma, and fears and the role of the faith community in HIV prevention and care. The aim was for participants to take away from the meeting the ability to understand HIV from an evidence-based perspective, ability to discuss the topic of HIV, and feel more comfortable with counseling and offering resources. In addition, there was a discussion of how each specific organization can sustain HIV stigma-reduction and HIV education efforts in the organization.
- **June 2012: HIV Stigma Training.** Five-hour workshop held at one of partner churches on a Saturday morning to explore beliefs about those living with HIV. The curriculum was modeled after the National Minority AIDS Council’s and the Health Resources and Services Administration’s (HRSA’s) program, “HIV/AIDS Stigma and Access to Care.” Our program was titled, “Faith Communities Working Together: Overcoming Stigma, Encouraging HIV Testing and Embracing with Compassion.” Activities included videos, role plays, patient stories, question and answer. Small group dialogue was encouraged. Academic and community partners co-facilitated training. This training provided an opportunity for churches to open up about fears and concerns and to learn facts. Trust building was a key component of this training along with open dialogues; no topic was a taboo.
- **August 2012: Town Hall Faith-Community Mobilization and Discussion Forum, featuring Phil Wilson, Director of the Black AIDS Institute, as the keynote speaker.** The program, open to a broader faith, research, and clinical community, begun with status updates on the ongoing church programs with vignettes of the path the process has taken in the churches. Phil Wilson provided additional educational updates and encouragement about confronting HIV in the community. The program addressed the role of researchers, community participation in research, and any ethical issues, in case new organizations were

interested to join as participants in the project. Data were collected from random participants via pulse interviews about what they believed the challenges and opportunities were to address HIV in faith communities.

- **February 2013: Closing Ceremony.** Two-hour event to discuss one-year progress, conclude the program, and recognize the participating churches. Representatives of the participating churches made presentations about individual programs and outcomes. A Call to Action was issued and consented to as further commitment from the participants to continue addressing HIV in their organizations.

## Appendix C

### **Semi-Structured Questionnaire for Community, Clinical, and Research Partners Addressing Assessment of the HIV Partnership and Community-Engaged Project**

1. Why were you interested in being part of the partnership? Why do you think the community folks were interested in the partnership?
2. Most important aspect of project
3. Most difficult aspect of the project
4. The best/worst part of the partnership
5. Would this partnership have worked with other members of the academic/professional community or with other members of the Black faith community—why or why not?
6. What role do you play within the academic/professional community here in Cincinnati? Are you an insider in that community?
7. What role did the community members play in the partnership since they were mostly outsiders to the academic/professional community? For example, did X's role differ from Y's? Does job position matter? What about people who had overlap in academics and community?
8. What skills, expertise did you bring to the table and how was that similar or different than what the community brought to the table?
9. If you were talking to someone who was thinking of doing this in the future, what would you tell them? What do you want to tell them about why they should do it? What would you warn them about?

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Elliott Cuff; Turning Point Church of Zion—Pastor James Bready; Light of the World Ministries—Pastor Mike Scruggs; St. Mark A.M.E. Zion—Pastor Jermaine Armor; Bethel Baptist Church—Pastor Wayne Davis; Tried Stone New Beginnings—Pastor Jerry Culbreth; Inspirational Baptist Church—Pastor Victor Couzens; World Outreach Christian Center—Pastor Gregory Chandler; and, Second Trinity Church—Pastor Kenneth Bibb.

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